A STUDENT CONTRIBUTION

The Specter of Malpractice

GEOFFREY E. LINBURN, M.D., *Denver*

THE SPECTER OF MALPRACTICE haunts many physicians. To these physicians the threat of being held publicly accountable for their professional actions arouses considerable anxiety. In an effort to allay this anxiety they have sought culprits whom they can blame for their distress. By this path they have been led to believe in a legal conspiracy. In this conspiracy, they believe, opportunistic patients bring suits against the innocent doctor, mercenary lawyers encourage such suits, naive juries sympathetic to the injured patient bring in large verdicts, and courts continue to extend rulings prejudicial to the doctor.

Defensive Medicine

Physicians' defense against this conjured threat has taken several forms. One form of defense has been the practice of defensive medicine. From fear of possible litigation, valuable procedures such as caudal anesthesia have been tabooed while overdiagnosis with the excessive use of x-rays and laboratory tests has become commonplace. These policies have deprived patients of valuable medical procedures and have imposed unnecessary expenses and hazards.

The "Conspiracy of Silence"

> The only evidence that can decide a case of malpractice is expert evidence: that is, the evidence of other doctors; and every doctor will allow a colleague to decimate a whole countryside sooner than violate the bond of professional etiquette by giving him away . . . He is not sure enough of his own opinion to ruin another man by it. . . . I do not blame him: I should do the same myself. But the effect of this state of things is to make the medical profession a *conspiracy* to hide its own shortcoming. [Emphasis added]
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> —G. B. Shaw, *The Doctor's Dilemma*[1]

These observations indulgently expressed by George Bernard Shaw more than a half century ago were more recently transformed by the well-known plaintiff lawyer, Melvin Belli, into the more bellicose designation of a "conspiracy of silence."[2] This heated phrase emerged from the kiln of malpractice litigation in which plaintiff lawyers were frequently frustrated in their attempts to obtain medical testimony. To a 1957 *Stanford Law Review* questionnaire, 16 of 21 plaintiff lawyers in California responded that obtaining medical testimony for their clients was almost impossible to outright impossible.[3]

The reluctance of physicians to provide testimony establishing a standard of care has also been widely recognized by the courts. In *Salgo v. Stanford* (Cal., 1957), for example, Justice Bray observed that ". . . gradually the courts awoke to the so-called 'conspiracy of silence.' No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence."[4]

Since in most malpractice cases the expert testimony of a physician is required to establish the standard of care by which the defendant physician's conduct is to be judged, the refusal by physicians to provide such testimony may lead to the dismissal of the plaintiff's suit for want of sufficient evidence. The patient is thereby deprived of his legal right to damages for negligent injuries.

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At the time he submitted this paper for publication, the author was a fifth-year student at Stanford University School of Medicine. He received his doctorate in medicine in June of this year and is at present interning at Denver General Hospital in Denver.

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Reprint requests to: 330 East Tenth Avenue, Denver, Colorado 80203.

While the California courts have not directly repudiated this tactic, they have tried to help the plaintiff out of his predicament by stretching old rules of evidence and formulating new ones. In California, for example, drug company brochures are admissible as evidence pertinent to establishing the standard of care for drug administration.[4] The California courts have also liberalized the qualifications of an expert witness. Originally, negligence of a physician was measured against the reasonable standard of care practiced in the physician's community and established by the testimony of local physicians. But since physicians from the same community as the defendant are less likely to testify against the defendant than physicians from another community, the courts have attempted to liberalize the qualifications of an expert witness to permit physicians from other communities to testify. In *Sinz v. Owens* (Cal., 1949), for example, the California Supreme Court qualified an expert witness from another community on the grounds that he was familiar with the standards required of physicians "under similar circumstances" to those applying to the defendant.[5] In the event that no other physician can be obtained to testify, the defendant physician himself may be used as an adverse expert witness by the plaintiff lawyer to establish a standard of care.[6]

The most significant development in the attempt by the California courts to circumvent the "conspiracy of silence," however, has been to extend the application of the doctrine of *res ipsa loquitur*. Originally intended as a rule of circumstantial evidence ("the thing speaks for itself"), the doctrine has been extended in some circumstances to impose an obligation on physician defendants to advance evidence of non-negligence. In the usual negligence case, the burden of proof rests with the plaintiff who presses charges. But since malpractice litigation generally requires the testimony of physicians establishing a standard of care by which the case can be judged, the difficulty in obtaining such testimony provoked the courts into extending the application of *res ipsa loquitur* to impose some burden on the medical profession to provide such testimony. The intent behind so applying the doctrine has been to permit the plaintiff patient his day in court. The danger in so applying the doctrine to malpractice cases has been to unjustly imply the guilt of the physician.

Over the past decade the California Medical Association has tried to make available expert witnesses to plaintiff lawyers through the establishment of medical expert panels.[7,8] Although these efforts have helped to make medical testimony more available to the plaintiff, plaintiff lawyers continue to complain that adequate medical testimony is still difficult to obtain.

Speak No Evil

A final form of defense against the specter of malpractice has been the frequent, tacit agreement among physicians not to hold one another accountable for a standard of care. Local medical societies, for example, have made little effort to enforce such a standard. A survey by the American Medical Association of 1,100 county medical societies revealed that in a period of two years only 21 physicians were expelled. Of these 21, only four were expelled for offenses against patients.[9]

Certified hospitals are one area in which the medical profession has made significant efforts to scrutinize its own practices. Surveillance of the professional staff is accomplished by review of qualifications on admission to staff, restriction of privileges, and record and tissue review committees. However, even in accredited hospitals the practices of most physicians on non-surgical services is reviewed very casually; little or no work of any kind is reviewed in non-accredited hospitals; and office practice is not reviewed at all.

By largely abdicating the responsibility for maintaining a standard of care, physicians have left this territory for the legal profession to regulate.

The Inner War

In attempting to defend themselves against what they appear to believe to be a "legal conspiracy," physicians have engaged in a battle which has damaged both medical practices and legal processes. Meanwhile the specter of malpractice looms larger than ever.

The Illusory "Conspiracy"

Although examples can be found to support the belief in a legal conspiracy that significantly harms the innocent physician, the weight of evidence is contradictory. Only in the exceptional case is the physician unjustly convicted of malpractice.[10] And even more exceptional is the conviction which significantly harms the physician.[11] Malpractice insurance is available to practically every physician[12]; and the high cost of such insurance is generally defrayed by the public by increased medical fees.

The only well-documented finding lending support to the belief in a legal conspiracy is the high proportion of malpractice claims that have little medical merit. In a study of the causes of malpractice claims in California, Richard Blum observed that not more than 10 percent of malpractice claims are based on actual malpractice.[13]

But while physicians have been understandably indignant at having to publicly discredit unmerited accusations, this provocation, as with the other reasons usually cited, does not adequately account for their defensive behavior. In the first place, there is little evidence to suggest that doctors distinguish between those cases with and those without medical merit in reaching their decision as to whether or not they will testify—most physicians will not testify regardless of the medical merits of the case. Furthermore, the practice of defensive medicine seems to be conditioned more by a general desire to avoid any malpractice claim than by a discriminant concern to frustrate unmerited claims.

Although the possibility of a malpractice suit is real, the "legal conspiracy" which many physicians envision is a distortion of the actual threat. The risk of malpractice admittedly is sufficient to warrant a physician's carrying malpractice insurance. But the risk realistically recognized by carrying such insurance is of a different order from that sufficient to substantiate the belief in a legal conspiracy which has led to the practice of defensive medicine and to the so-called "conspiracy of silence."

The Need for an Illusion

Although the belief in a legal conspiracy has little objective validity, compelling reasons exist to explain its subjective necessity. "In the United States today the physician typically enjoys to an unusual degree good income, social prestige, and the esteem of the community. Little in his training or environment conditions him for criticism, deprecation, or attack."[14] Medicine has attracted many persons who thrive in this aura of respect and come to depend on it. In turn, they often come to half believe in the public's unrealistic expectations of their dedication and wisdom on which this respect is based. Such physicians have particular difficulty comprehending and tolerating the discrepancy between the respect to which they are accustomed and the indignity of a malpractice suit. Their inability to acknowledge their need for this uncritical respect leads them to envision a legal conspiracy. By then acting as if they were defending themselves against this envisioned conspiracy, they are able to defend their self-esteem without having to acknowledge this need.

While the need for uncritical respect varies for different physicians, it tends to be greatest in those most vehemently opposed to and most commonly involved in malpractice litigation. In Blum's study on the causes of malpractice,[13] it was found that doctors involved in multiple suits—they are termed "suit-prone"—have personality profiles that differ significantly from those of doctors involved in one or no suits. The suit-prone doctor is more likely to be immature, to have low self-esteem, to have difficulty handling emotional problems, to dislike his patients yet want them to be dependent and grateful, to act as if he were infallible—preferring not to have consultants and tending to blame others for his own mistakes, and to be defensive. Such a doctor, according to this study, is more likely to antagonize his patient who, in turn, because of the taboo against expressing anger in a doctor-patient relationship, may express his anger in the more acceptable form of a malpractice suit. For such a doctor the need to believe in a legal conspiracy is particularly compelling.

Created largely as a defense to protect physicians' threatened self-esteem, the belief in a legal conspiracy has led these physicians to act in such a way as to perpetuate and even aggravate the very situation which they wish to eliminate. Their distrust of the legal system governing malpractice has engendered responses by this system which confirm this distrust. This self-fulfilling prophecy is most apparent with the suit-prone doctor. Such a doctor is more likely to provoke an emotionally based suit of questionable medical merit. His initial distrust of the legal system, reflecting his tendency to blame the system rather than himself, is reinforced by such a suit. Feeling threatened by the legal system, such a physician may attempt to retaliate by refusing to offer expert testimony. This tactic provokes new extensions of *res ipsa loquitur,* which further reinforce his distrust of the system.

The Double Bind

In a malpractice suit, however, the physician is confronted not only by his own internal conflicts but also by the public's conflicting attitudes toward the physician. Ordinarily, the public tends to re-

gard the physician as infallible and encourages him to behave as if he were; but in a malpractice suit, the physician is cast in a role diametrically opposed to his ordinary role. If he accepts the public's initial expectation of his infallibility, the challenge of a malpractice suit becomes unresolvable. In this way the public places the physician in a double bind from which the only escape is to retreat to a defensive position. Unable to admit to any error even to himself, the physician must either deny or justify his actions.

By restricting the definition of a physician's negligence to only those cases involving injury to a patient, the courts have further reinforced this defensive attitude. The physician has a hard enough time admitting to any error in public; but because of the additional guilt which he feels when his error leads to injury, he becomes even more defensive. It is also easy under the existing malpractice law for him to rationalize his defensive attitude by pointing to the high proportion of malpractice claims with little medical merit.

Toward a Peaceful Settlement

Legal Revisions

The legal profession has made it difficult for physicians to respond constructively to the challenge of malpractice. Even when physicians have tried to regulate medical practices, as in accredited hospitals, they have been frequently thwarted by the difficulty in obtaining legal sanction. A recalcitrant physician who has been denied hospital privileges may turn around and sue the hospital for depriving him of a means of livelihood; and it is often extremely difficult and invariably laborious to demonstrate in court sufficient grounds for the withholding of hospital privileges. Further support by the legal profession of physicians' efforts to regulate medical practices would help to encourage more of such efforts.

It has also been difficult for physicians to respond constructively to a malpractice law which simultaneously seeks to discipline negligent doctors and to compensate injured patients. By pursuing these divergent purposes under the aegis of one law, the courts have limited the legal sanction of malpractice to that small proportion of violations of the standard of care which leads to injury. Under such a law, the financial settlement is proportional to the seriousness of the injury; whereas the seriousness of the injury may bear little relationship to the quality of medical care. In part due to this frequently haphazard relationship and to the withholding of the sanction from the many violations not resulting in injury, many physicians have developed a cynical attitude toward malpractice litigation as a means of maintaining a standard of care. The restriction of the sanction to those cases involving injury also selects cases in which physicians are least likely to admit to their error. Because of the guilt associated with injury to a patient, physicians in these instance are more likely to "justify" their behavior than to change it.

The present law also limits the right to recovery to a small proportion of the injured patients.

By subsuming under one law the enforcement of a standard of care and the right to compensation for medical injuries, the courts have severely limited the extent to which either objective can be achieved. Both objectives could be better achieved if the law were revised to make them independent of one another.

Abandoning an Illusion

The dual purpose of malpractice law, however, has been vital to enforcing a standard of care. Since the only legal sanction at present available to help enforce a standard of care is the payment of damages by the negligent doctor, the legal profession is not likely to relinquish this sanction without evidence that the medical profession will assume more responsibility for enforcing such a standard. Although the medical profession is not directly responsible for the present legal system governing malpractice, it can deny all responsibility for this system only at the peril of denying itself any constructive role in the future shaping of this system. While physicians have not formulated the present malpractice law, they have affected its formulation by their behavior—by failing to enforce a standard of care, they have obligated the legal profession to assume this responsibility; by refusing to give expert testimony, they have provoked the courts into extending the doctrine of *res ipsa loquitur*.

Physicians are deluding themselves if they expect that their repudiation of the legal system will make the system relinquish its authority over them. To the contrary, it can be expected that the legal profession will become more authoritarian in proportion to the degree to which the medical profession repudiates its authority.

Physicians also cannot expect the legal profession to initiate the changes they desire; for the legal profession does not share physicians' disaffec-

tion with the existing legal system governing malpractice. Lawyers personally have little to lose under this system; and plaintiff lawyers, with the lucrative fees available, may indeed have much to gain. In the main it is physicians, not lawyers, who are disturbed by the present system.

Yet by taking the attitude that they are being persecuted by the legal system and that the only way to contend with such a system is by opposition, physicians have selected the strategy which is least likely to bring about the changes they seek. Physicians can continue to repudiate the legal system and bear the consequences. But if they are to entertain any realistic hope of improving the situation, they will have to accept the present legal system as a *modus vivendi* while directing their efforts toward more satisfactory alternatives.

Coexistence

Adoption of this approach would imply several paths of action. It would imply cooperation with the existing legal system. Such cooperation would include a willingness to provide expert medical testimony in all malpractice cases. The establishment of medical expert panels represents a move in this direction.

It would also imply support of the recent efforts of many local medical societies in forming medical review boards to assist the malpractice insurance companies. These boards have reviewed malpractice claims and have rendered opinions on their medical merits, recommending contesting of unwarranted claims and settlement of legitimate claims. Defense lawyers and, increasingly, plaintiff lawyers also have come to respect these opinions, thereby avoiding much unnecessary litigation. The salutary effect of these boards gives some hint of the possible prospects of responsible cooperation with the legal system.

Self-Government

But beyond responsible cooperation with the existing legal system, successful efforts toward improving the regulation of medical practice will have to include more efforts by the medical profession to regulate itself. Physicians' most common criticism of malpractice law has been that lawyers and laymen are not properly equipped to evaluate the niceties of medical practice. Yet these same doctors have withheld testimony needed to reach an informed evaluation; while at the same time they have made little effort on their own to enforce a standard of care. Under these circumstances the legal profession has had little alternative to assuming responsibility for evaluating medical practices.

Professional Priorities

By conjuring a legal conspiracy, physicians have been able to legitimatize their anxiety over the threat of malpractice. This maneuver has enabled them to suppress the more personal threat posed by a malpractice suit. But this gain has been purchased at the price of mounting anxiety at having to continually maintain a defensive position against an ever more powerful foe. This defensive position indeed has perpetuated the very problems of malpractice which it sought to eliminate, both in an objective sense by aggravating existing legal difficulties and prompting defensive medical care and in a subjective sense by conceptualizing the situation as a menace to be avoided rather than as a responsibility to be confronted.

Advice to physicians about malpractice has often supported this position by emphasizing ways to avoid malpractice suits.[15,16] By implicitly recommending the practice of good medicine as secondary to avoiding a malpractice suit, such advice, albeit inadvertently, acknowledges and thereby revives the defensive mentality from which the specter arose. This preoccupation with the specter of malpractice has at times diverted physicians from their primary responsibility to provide good medical care. Were physicians to consistently regard good medical care as their primary responsibility, the specter would dissipate.

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